STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from the Court of Appeals
Docket No. 231804

ADVOCACY ORGANIZATION FOR PATIENTS & PROVIDERS, a non-profit Michigan corporation et al,

Plaintiffs-Appellants,

v.

Docket No. 124639

AUTO CLUB INSURANCE ASSOCIATION, a Michigan corporation et al,

Defendants-Appellees.

DEFENDANTS-APPELLEES' BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

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TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

Statutes

Other Authorities

Rules

COUNTERSTATEMENT OF BASIS OF JURISDICTION

The brief filed by Plaintiffs/Appellees did not contain a statement of the basis of the Court's jurisdiction. This Court has jurisdiction over this matter pursuant to its Order granting leave to appeal entered on June 25, 2004. The appeal is from a decision of the Court of Appeals dated July 3, 2003.

COUNTERSTATEMENT OF QUESTIONS PRESENTED

I. DID THE COURT OF APPEALS PROPERLY REJECT PLAINTIFFS' POSITION THAT MEDICAL PROVIDERS CAN CHARGE WHATEVER FEE THEY DESIRE TO TREAT NO-FAULT AUTOMOBILE ACCIDENT VICTIMS WITHOUT REGARD TO WHETHER THE FEE IS REASONABLE, WHERE PLAINTIFFS' POSITION IS CONTRARY TO THE NO-FAULT ACT AND THE DECISIONS OF THIS COURT, THE COURT OF APPEALS, AND THE SIXTH CIRCUIT COURT OF APPEALS?

The trial court would say "yes."

The Court of Appeals said "yes."

Plaintiffs would say "no."

Defendants would say "yes."

II. DID THE COURT OF APPEALS PROPERLY DISMISS PLAINTIFFS' CONSPIRACY CLAIM WHEN THERE IS NO UNDERLYING TORT TO SUPPORT THE CLAIM, AND THE ALLEGATIONS OF CONSPIRACY ARE INADEQUATE AS A MATTER OF LAW?

The trial court would say "yes."

The Court of Appeals said "yes."

Plaintiffs would say "no."

Defendants would say "yes."

III. DID THE COURT OF APPEALS PROPERLY DISMISS PLAINTIFFS' TORTIOUS INTERFERENCE CLAIM WHERE PLAINTIFFS SEEK TO ENFORCE AN UNWRITTEN AGREEMENT TO REQUIRE PATIENTS TO PAY UNREASONABLE MEDICAL FEES DESPITE THE EXPRESS LANGUAGE OF THE NO-FAULT ACT REQUIRING MEDICAL PROVIDERS TO CHARGE A REASONABLE FEE?

The trial court would say "yes."

The Court of Appeals said "yes."

Plaintiffs would say "no."

Defendants would say "yes."

INTRODUCTION

The core of plaintiffs' case is that medical providers have no obligation to comply with the unambiguous mandate of MCL 500.3157 that they "charge a ***reasonable*** amount for the products, services and accommodations rendered" when they treat patients entitled to benefits under Michigan's No-Fault Act. Plaintiffs argue that medical providers are entitled to charge whatever fee they deem appropriate, so long as they charge their patients without insurance the same fee -- reasonable or not. Plaintiffs' position is contrary to the express language of Michigan's No-Fault Act, and has been rejected by each court that has considered it. Each of these courts reached the inescapable conclusion that the No-Fault Act expressly permits an insurance carrier to review medical invoices for reasonableness of the fees charged.

The plaintiffs, and the amici supporting them, have attempted to recast the issue in this appeal, by focusing on dicta in the decision of the Court of Appeals addressing one review methodology used by one medical review company, and only a few of the insurance carriers. Defendants have never argued – and do not contend here – that they have the unilateral right to determine whether a particular fee is reasonable. The defendants also do not contend that there is some "fee schedule" that is binding upon the parties, or that the so-called "80th percentile test"[1] is a binding determination of reasonableness. Defendants' position, simply stated, is that a provider's fee is not reasonable as a matter of law solely because that fee represents the "customary" fee to charged to those patients without insurance. Rather, reasonableness of fees must be addressed on a case by case basis, with each party entitled to dispute the conclusions of the other party in a court of law.

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[1] As set forth *infra*, there is no such thing as the "80th percentile test."

The conclusion that plaintiff providers are limited to charging a reasonable fee, and the no-fault carriers are obligated to pay it, is compelled by the plain language of the statute. If the Court agrees with this straightforward principle of law, then the Court of Appeals reached the correct result, and its decision must be affirmed. The dicta addressing the "80th percentile test," while an accurate description of one review methodology used by one medical review company, does not establish a binding standard to be used by a court or jury when it considers whether a particular fee is reasonable. While the parties may find it inefficient to address this issue on a case-by-case basis, that public policy decision is one that can only be made by the Legislature, not by the parties or the courts. The holding of the Court of Appeals should be affirmed.

COUNTERSTATEMENT OF FACTS AND PROCEEDINGS

A. Counterstatement Of Facts.

This case was decided on cross-motions for summary disposition based on the legal issues presented.[2] In their Brief, plaintiffs attempt to create the impression that insurance carriers writing no-fault automobile insurance in the State of Michigan behave in a monolithic manner, all conducting the same type of review of medical invoices, and all failing to pay the majority of the invoices submitted to them by medical providers. This impression is contrary to the record created before the lower court. The undisputed record demonstrates that there are substantial differences in how each insurer approaches the payment of invoices submitted by health care providers, and that such approaches have varied over time. For example, while some insurers in the early 1990s may have compared medical invoices to the workers' compensation schedule of approved fees, there was no evidence presented to the lower court that would support a

[2] Before the lower court, plaintiffs also sought class certification of an ill-defined class. The motion for class certification was denied, and the Court of Appeals affirmed. Plaintiffs did not seek this Court's review of this issue.

conclusion that any carrier currently engages in this practice. As case law has changed through the years, the carriers have also changed their practices and their databases to reflect developments in the case law. It is important for the Court to understand the uniqueness of each carrier's process for reviewing medical invoices when evaluating plaintiffs' claims here.

1. Plaintiff-Providers Represent a Diverse Group.

Because of the scope of the medical specialties and the nature of automobile accidents, the provider plaintiffs represent the entire gamut of medical practice, from podiatrist to psychiatrist, from arthroscopic surgery to zooplasty. While some providers are engaged in the same medical specialties, most are not. Each specialty encompasses a broad range of medical procedures, some simple and some complex, justifying different levels of fees. Some providers are solo practitioners whereas others practice as part of a group, and thus have differing overhead costs to factor into their fees.

Beyond the wide diversity of their practices and the resultant diverse factors incorporated into their fee structures, plaintiff-providers admit that they each set their fees for no-fault patients completely independently of one another, and without consultation with any other medical provider outside of their practice groups. (See App. p. 12b.)[3] Because each provider's fee structure is unique, each one must be considered independently by a factfinder to determine whether each particular charge is reasonable.

The diversity among the fees charged by the named plaintiffs is amply demonstrated by their interrogatory responses. In response to Defendants' Second Set of Interrogatories, Request 9 (App. p. 14-31b), plaintiffs identified the amounts they charge for medical procedures which

[3] The affidavits and documents referenced herein are contained in the accompanying Appendix. These documents were attached to Defendants' Brief Opposing Class Certification before the lower court. (Dkt. #143.)

are identified by standard procedure codes established by the American Medical Association and known within the healthcare industry as Current Procedural Terminology or "CPT" codes. A spreadsheet compiling the plaintiffs' discovery responses dramatically illustrates the differences among the plaintiff providers and the fees they charge for the same service and as identified by the ascribed CPT codes.[4] (App. p. 32b.)

Another key difference among providers is whether they have entered into contracts with insurers establishing agreed-upon fees that will apply to the treatment of their no-fault patients. For example, many providers, including some of the named plaintiffs here, executed contracts with Citizens Insurance Company of America agreeing upon the fees they would charge and be paid for treating no-fault patients. (App. pp. 33-36b.) Both Citizens and Frankenmuth Mutual Insurance Company have agreements with the Preferred Provider Organization of Michigan, which covers approximately 18,000 providers (including many named plaintiffs), whereby the providers and the insurers contractually agree upon the fees charged and paid. (App. pp. 33-36b; 37-39b.) Still other providers have contracted with State Farm Insurance Company or Manageability to charge predetermined fees. (App. pp. 40-42b.) Other providers belong to the Medview Network, in which providers agree to accept fees less than those billed in exchange for the certainty of payment. (Dep. of Dianne Mateja, pp. 80-82, App. 54-56b.)

Some review companies, such as MedAudit and Linkage, routinely reach individually negotiated fee agreements with providers when the review companies conclude the fees are

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[4] For example, while plaintiffs Russell and Waterbrook charge $60 for an expanded office visit (CPT #99231), plaintiffs Bengtson, Ringler, VanderWall & Moore charge $37 for the identical procedure code. Thus, Russell and Waterbrook charge 62% more than their co-plaintiffs for the same procedure. For CPT #99233, subsequent hospital care per day, Russell and Waterbrook charge $100, or 72% more than the $58 charged by Bengston, et al. Plaintiffs Uitvlugt and Stephens charge $125 for CPT # 99233, well over twice what Bengston, et al., charge. Plaintiff Merriman charges even more for this treatment, $139, 140% more than Bengston, et al.

excessive. (App. 56-59b; 37-39b). Whether the provider has entered into such contractual agreements, and whether the provider has entered into such agreements with one defendant or many, thus varies from provider to provider.

2. Each Individual Patient Presents A Different Situation.

Just as providers present numerous individual business practices that require individual scrutiny, so do their patients. The patient plaintiffs present as much diversity in their injuries and treatments as do the providers in terms of their treatments and charges. While one patient may have suffered a catastrophic injury necessitating extensive medical treatment (such as plaintiffs Brown and Colvin), many patients sustain minor injuries requiring minimal medical treatment.

Moreover, the reason that patients receive coverage for no-fault medical benefits differs from patient to patient. Some patients, like plaintiff Colvin, are insureds — i.e., they purchased a policy of automobile insurance. (App. pp. 112-113b.) Other patients, such as plaintiff Brown, are receiving personal injury protection medical benefits because they were passengers in an automobile at the time of the accident and had no insurance policy of their own upon which they could draw benefits. (App. pp. 114-115b.) Therefore, under Michigan's no-fault priority system, they are receiving no-fault PIP benefits, but not from a carrier who sold them a policy of insurance. Other individuals are eligible to receive no-fault PIP benefits because they are family members of insureds, employees, pedestrians, bicyclists, occupants, assignees, or out-of-state residents under various provisions of the No-Fault Act, even though they did not purchase an insurance policy from any of the defendants. *See* MCL 500.3111, 3114, 3115, 3163, 3104.[5]

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[5] There are also variations in applicable insurance coverage among patients receiving PIP benefits. For example, some patients have a coordination of benefits provision in their no-fault or health care insurance policies, others do not. Other differences include whether or not the no-fault insurance is subject to coordination with a health plan covered by ERISA, and differences in the deductibles charged to the patient. Some putative class members purchased an

The patient plaintiffs also differ in whether they ***want*** their no-fault carriers to engage in much of the conduct that is challenged in this action (*e.g.*, advising the insured that he or she need not pay fees not covered by the no-fault carrier, and that the carrier will defend and indemnify the insured/patient if the provider sends the unpaid excess to collection). Some patient putative class members are repeatedly threatened with litigation by their providers and need their carriers to intervene to deal with balance billing and collection practices of providers. (App. pp. 116-145b, sample of letters from providers threatening patients). For example, Auto Club has stepped in on behalf of plaintiff Johnny Brown on multiple occasions to address threatening letters from providers. (App. pp. 60-108b.) While plaintiffs theorize that there are patients who object to this intervention, they have yet to identify one who does.

3. Defendants Are a Diverse Group, With Unique Review Practices.

As varied as plaintiffs' rates and billing practices are, defendants' review and payment practices are at least as diverse. The defendants do not use any one common system of reviewing the invoices of medical providers. The carriers use different databases, different criteria, and different personnel to assist them in evaluating whether they consider a particular charge to be reasonable. While plaintiffs attempt to create the impression that all the defendants are using the 80th percentile so-called "test," that argument has absolutely no support in the record, as only a fraction use this "test".

Some defendant insurers use outside review companies to conduct retrospective review of medical invoices; some do not. For example, Auto-Owners and Farmers Insurance Exchange rely on an outside review company, Review Works, which regularly updates its database such

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insurance policy at a discounted rate in which they agreed to seek pre-certification of all non-emergency medical treatments, thereby voluntarily limiting their treatment options. (App. pp. 40-42b.) These differences impact whether a patient is affected by the claims review standards implemented by his or her automobile insurance carrier.

that claims submitted at different periods of times are evaluated against a different database of information.[6] Farm Bureau used various procedures over the alleged class period to evaluate medical bills, and at the time of the motion before the lower courts, used MedAudit, which uses a different, evolving database other than Review Works to evaluate claims.[7] Frankenmuth, Secura, Titan and Wolverine have used several different review companies, including MedAudit, Manageability, Linkage, Occupational Services Company and/or CSA.[8] On the other hand, Citizens and Allstate relied on reviews conducted by their own employees using proprietary computer databases which are periodically updated.[9] Some carriers, such as State Farm, have used a combination of inside and outside review, and a variety of individualized review processes over the years.[10] Some carriers, such as TIG, used review companies for only a portion of the alleged class period.[11] Some companies, such as Auto Club, changed review companies and review protocols during the alleged class period.[12]

The defendant review companies are just as individualized. Different review companies use different methodologies for their claims review processes, and update those processes regularly.[13] Even during a period in which a particular carrier may be using a particular outside

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6 Kael and Cornish Affs., App. pp. 109-111b, 146-153b; Mateja Dep., pp. 63-66, App. pp. 50-51b.

7 Kuebler Aff., App. pp. 56-59b

8 Weigand, Pinter, Gleason, and DeBruin Affs., App. pp. 37-39b, 154-55b, 156-57b, 158-59b.

9 Yardley and Wegener Affs., App. pp. 33-36b, 112-113b.

10 Lollar Aff., App. pp. 40-42b.

11 Neilson Aff., App. pp. 160-163b.

12 Lanctot Aff., App. pp. 60-108b.

13 Lanctot Aff., App. pp. 60-108b, and Mateja dep., pp. 62-71, App. pp. 50-52b.

review company, the carrier may not send all claims to outside review, but rather determine which claims to send out based on company-specific "triggers." Other carriers submit all their claims for outside review.[14] Moreover, even where outside review is used, carriers generally treat the outside review company's recommendation as just that, leaving room for individualized determinations on a carrier-by-carrier, case-by-case basis.[15] Simply put, no two defendants are alike.

4. The 80th Percentile "Test" Is A Misnomer Placed On A Review Methodology Used By Review Works And Some Insurers To Make An Initial Evaluation Of Whether A Fee Is Reasonable.

In *dicta*, the Court of Appeals reviewed one methodology used by some of the insurance carriers to make an initial evaluation of the reasonableness of medical invoices. Plaintiffs spent a great deal of attention on this issue in their application for leave to appeal, and the amici focused almost exclusively on this issue. The key point that is lost in this smokescreen is that defendants have never advocated for a "80th percentile test," and do not advocate that position here. Because the Court instructed the parties to address this issue, however, defendants provide additional information to the Court concerning the process used by one of the medical auditing companies, Review Works.

Dianne Mateja, the program director for Review Works was deposed in the case. Ms. Mateja, a registered nurse, was in charge of the development and maintenance of Review Works' medical bill review programs at the time of her deposition. Ms. Mateja echoed the position of the defendants in this case, when she testified that the No-Fault Act does not contain any rules or fee schedules that apply to the review of medical invoices. (Mateja, p. 33, App. p. 54b.) Ms.

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[14] Cf. Kael Aff., App. pp. 109-111b, and Wiegand Aff., App. pp. 37-39b

[15] See e.g., Kael Aff., App. pp. 109-111b; Cornish Aff., App. pp. 146-53b and Neilson Aff., App. 160-63b.

Mateja testified that the database utilized by Review Works depends heavily on current procedural codes, known as "CPTs", that are developed by the health care industry to designate the type of medical service provided. The CPT codes are published by the American Medical Association and updated annually. (Mateja, p. 23, App. p. 44b.) Those CPT codes are then supplemented with codes developed by other organizations to cover gaps in the AMA codes. For example, the Health Care Finances of America ("HCFA") publishes additional billing codes and publishes forms for health care providers to use in submitting their charges for reimbursement. (*Id.*, pp. 23-25, App. p. 44b.)

The Review Works system is set up to "flag" certain things for further review. For example, if a provider has used a CPT code that would not generally be associated with an automobile accident, the entry would be flagged for further review. The computer system also compares the diagnostic code to the CPT code to review whether the relationship between them makes sense. (*Id.* pp. 50-52, App. p. 58b.) The computer also conducts a utilization review regarding the number of visits made to a particular provider for the same problem, and other similar issues. (*Id.*, pp. 44-49,. App. 46-47b.)

Review Works also programmed into its database a system to review fees for reasonableness. The database represents a compilation of CPT and other codes, so that each entry for a particular service rendered can be compared to the identical service codes used by other physicians. For each CPT code, data is input into the system that reflects charges that were submitted by all providers in Michigan the previous year for the exact same CPT code. For codes that are used more frequently, Review Works will update the information in its system more frequently. Therefore, on any given day, the database will contain information on what the

providers in the State of Michigan charged for each CPT code. (Mateja, pp. 63-66, App. 50-51b.)

Because the information in the database is generated from the actual charges by physicians treating no-fault patients, the providers determine the content of the database. For example, if every provider in the State charges $1,000 to set a broken arm of a no-fault patient, the database will so reflect. (*Id.* at pp. 68-69, App. p. 51b.)

Those insurance companies using Review Works transmit information regarding medical bills received to Review Works in a variety of ways. Review Works will review the invoices to determine if the provider has used the correct CPT code, whether the utilization reflects any issues, and whether the invoice is appropriate for payment at some amount. Only after this step are the invoices reviewed for the reasonableness of the charge by CPT (or other) code. Ms. Mateja described the use of the database to review the reasonableness of a fee per CPT code as follows:

> Q: Would you describe how you or what was the program you came up with for bill review in 1991 for no-fault?
>
> ***
>
> A: We used the 80th percentile of physician charges in the state of Michigan to determine the level of reimbursement that we would recommend as a reasonable amount of reimbursement to our customers.
>
> Q: Could you describe for us what that means to say you used the 80th percentile?
>
> A: We count each federal ID number as one, so it wouldn't matter whether one doctor did ten of something and another doctor only did one of something, they each got the same shot at it, they each got counted as one, so if you had a hundred providers who billed for a specific procedure code, where the 80th provider billed at, we considered that the reasonable amount, and we pay – we recommended payment of that provider and everybody below that

provider in full and everybody between the 80th and the 100th percentile we recommended payment at the 80th percentile.

Mateja, pp. 54-55, App. p. 59b.

The plaintiffs and the amici speculate about the source of the data used to perform Review Works' 80th percentile comparison. [16] None of that speculation has any basis in the record. For instance, there is no evidence in the record that the Review Works' database compares provider fees to the workers' compensation fee schedule. To the contrary, Ms. Mateja gave undisputed testimony that the data base does not use the workers' compensation fee schedule, or collect the fees charged by providers treating workers' compensation patients for purposes of comparison. (Mateja, p. 53, App. 48b.) There is no evidence that the database compares provider fees to the amounts charged to Blue Cross, Medicare, or any health care insurer. Rather, the evidence is that the only information used to construct the database is the charges rendered by providers treating no-fault patients and providing the same services as the provider whose bill is under review. Ms. Mateja testified:

Q: Where do you draw your database from for the annual, or in some cases more than annual, analysis of the 80th percentile?

A: We use the entire state of Michigan for that.

Q: And do you use actual provider bills for that?

A: Yes.

Q: And are these bills that come through your system?

A: Yes.

[16] The proposed amici as of this filing include the Coalition Protecting Auto No-Fault ("CPAN"), the Michigan State Medical Society ("MSMS") and the Michigan Hospital Association ("MHA"), all of whom speculate that because the Court of Appeals referred to a "survey" of charges, that Review Works must be incorporating charges made in workers' compensation situations, charges to Blue Cross Blue Shield and other health insurers. The undisputed record testimony, however, is that the "survey" is done of the charges made by Michigan providers to their no-fault patients.

Mateja, pp. 72-73, App. 52b (emphasis added). As a result, the providers determine the information that goes into the database, because *it is only their charges to no-fault patients* that are used in the evaluation of whether a particular fee per CPT code is reasonable.

Once the provider's bill is analyzed, Review Works then makes a recommendation to the insurance carrier regarding the amount that should be paid on each bill for each service. (*Id.*, p. 77, App. p. 53b.) The insurance company then has complete discretion to reject or accept the recommendation of Review Works, in whole or in part.[17] Of the millions of CPT code reviews that it does annually, Review Works recommends against paying the full amount of the invoiced fee in only a fraction of the cases. In a study performed by Review Works in 1996, it found that for every dollar that Review Works recommended not be paid by the carrier, only about seven cents out of that dollar was the result of a fee reduction for reasonableness. The other reductions recommended by Review Works pertain to other factors unrelated to the comparison with the "80th percentile" information in the Review Works database, such as utilization or necessary of treatment, for example. (*Id.*, pp. 71-73, App. p. 52b.)[18]

Plaintiffs' assertion at page 30 of their Brief that "there is also no route of appeal outside of small claims court for actions like this one" is false and, again, contrary to the record. In the event that a provider disagrees with an adjustment recommended by Review Works, and made by an insurer, the provider can request reconsideration. This process generally involves the

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[17] Review Works is compensated on a per line of code basis, and not on the basis of its recommendations, or on the basis of any purported "savings" achieved. (Mateja, p. 75, App. p. 53b.)

[18] The plaintiffs and amici are wrong that "20 percent" of provider charges are disapproved. All 100 of the providers in a given sample may be charging the exact same fee for a service, in which case all 100 are paid. This is why the recommendations by Review Works only reduce fees in about 7% of the cases, not 20%. Furthermore, it is not known how many times the carriers that use Review Works follow its recommendations or reject them, but certainly there is no record evidence that these recommendations are followed uniformly.

submission of additional information by the provider, and an evaluation of the submission by Review Works personnel. (*Id.*, pp. 78-79, App. 54b.) In addition, the carriers using the services of Review Works have their own independent review process established for the purpose of providing an informal dispute resolution process for the providers. It is only when these avenues fail that disputes go to the next level, whether through a lawsuit, arbitration, or other agreed upon resolution process.

5. Efforts To Amend The No-Fault Act.

Plaintiffs' Brief devotes substantial effort to convincing this Court that the insurance industry has supported reforms and revisions to the No-Fault Act from time to time. The Defendants do not dispute that they have made efforts to amend the Act throughout the years, but disagree completely with the implications that Plaintiffs claim arise from these efforts.

Reading Plaintiffs' Brief, one is left with the impression that the various proposals to amend the Act have all involved the issues presented in this case. Because those proposals did not pass, plaintiffs surmise that this acted as a rejection of the use of medical review companies to conduct an initial analysis for an insurance company as to whether a particular fee is reasonable or not. This argument is simplistic, and grossly misstates the history of the proposals to this Court. None of the proposals were a simple question of looking at a fee schedule for medical charges, and determining whether to accept or reject it. All of the proposals would have resulted, for example, in caps on the amount of medical benefits that would be recoverable by an auto accident claimant. All of them contained further limits on tort liability. It is impossible for anyone to conclude that simply because the proposals contained a fee schedule, that is the basis that the proposals were rejected.

Furthermore, even if that were the basis for the rejection, it is irrelevant, as argued *infra*. The Court of Appeals' decision here did not endorse a fee schedule, nor do the defendants argue that one exists.

6. Balance Billing.

Many of plaintiffs' complaints center around the actions of the insurer when the provider attempts to balance bill the insured. Plaintiffs would like to preclude the insurers from speaking on behalf of the patient/insureds or defending them when the providers attempt to take adverse action against those patient/insureds who decline to pay the balance of the bill. (Complaint, Count I, pp. 58-60). As set forth herein, Michigan law imposes the obligation on the insurer to act in response to a provider's demand for payment of no-fault benefits provided pursuant to the no-fault contract. This is also consistent with the Insurance Commissioner's interpretation of the No-Fault Act, as expressed in Bulletin 92-03.[19]

In the event that a provider disagrees with the payment received from the insurer, the provider can sue the insurer directly.[20]

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[19] In the Bulletin, the Commissioner noted that no-fault insurers are required to provide insureds and claimants with complete protection from economic loss for benefits provided under personal protection insurance. Auto insurers must act at all times to assure that the insured or claimant is not exposed to harassment, dunning, disparagement of credit, or lawsuit as a result of a dispute between the health care provider and the insurer, and to protect insureds and claimants from any consequences of such a dispute. Interpretive Statement, Bulletin 92-03 at pp. 1-2. The Michigan Court of Appeals in *McGill* acknowledged that the Commissioner's Interpretative Statement did not have the full force and effect of law, but noted that it generally gives deference to administrative agency interpretations. *McGill*, 207 Mich. App. at 407, n.1.

[20] *Lakeland Neurocare Centers v State Farm Mut Auto Ins Co*, 250 Mich App 35, 37-38; 645 NW2d 59, *lv den,* 467 Mich 909; 655 NW2d 554 (2002)(no question that health care provider had direct right to sue no-fault carrier); *Regents of the Univ of Mich v State Farm Mut Auto Ins Co*, 250 Mich App 719, 733; 650 NW2d 129 (2002) (provider had direct claims for PIP benefits).

B. Counterstatement Of Material Proceedings.

Defendants agree that the case was originally removed to federal court, and that the fraud, constitutional, and racketeering claims were dismissed by the Honorable Robert Homes Bell of the federal district court. (App. pp. 1b-11b.) The district court's decision was affirmed by the Sixth Circuit Court of Appeals in a comprehensive opinion rejecting the very crux of plaintiffs' case. *Advocacy Org of Patients & Providers v Auto Club Ins Ass'n,* 176 F3d 315, 320 (CA 6), *cert den* 120 S Ct 172 (1999) ("AOPP"). The United States Supreme Court denied plaintiffs' petition for a writ of certiorari that advanced many of the same arguments presented here. Defendants agree with the basic procedural history stated by plaintiffs after the case was returned to state court.

ARGUMENT

I. THE COURT OF APPEALS PROPERLY AFFIRMED DISMISSAL OF PLAINTIFFS' REQUEST FOR DECLARATORY RELIEF BECAUSE PLAINTIFFS' POSITION THAT MEDICAL PROVIDERS ARE PERMITTED TO CHARGE FEES IN WHATEVER AMOUNT THEY DESIRE IS CONTRARY TO THE EXPRESS REQUIREMENT OF THE NO-FAULT ACT THAT MEDICAL PROVIDERS MUST CHARGE A REASONABLE FEE FOR THEIR SERVICES.

Plaintiffs' key argument throughout this case is that if they certify that their charges are no higher than what they customarily bill to non-insured patients, insurers must accept those charges and cannot review the fees for reasonableness. Plaintiffs have advocated the extreme position that if their clients want to base their charge for a particular service "on the number of stars they happen to be able to count in the sky on any given night" they can do so. (App, p. 138a). Both parties asked the trial court to decide this issue as a matter of law, which it did. In their Brief on Appeal, plaintiffs attempt to redefine their position as a challenge to the various

methodologies used by insurers to determine whether the particular fees at issue are reasonable. As discussed *infra*, neither of plaintiffs' positions withstands analysis.

Matters of statutory interpretation are questions of law that are reviewed de novo. *Robertson v DaimlerChrysler Corp*, 465 Mich 732, 739; 641 NW2d 567 (2002).

A. The Statutes In Dispute.

This case involves the proper interpretation of the Michigan Automobile No-Fault Insurance Act, MCL 500.3101 *et seq* (the "No-Fault Act"). The No-Fault Act provides an "innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or "fault") system." *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978), *cert denied*, 442 US 934 (1979).

The key statutory provisions at issue in this case are § 3107 and § 3157 of the No-Fault Act. Section 3107 of the Act provides in pertinent part that "personal protection insurance benefits are payable for the following: (a) Allowable expenses consisting of all *reasonable charges* incurred for *reasonably necessary products, services and accommodations* for an injured person's care, recovery, or rehabilitation." MCL 500.3107(1)(a) (emphasis added). The equally clear language of Section 3157 of the No-Fault Act provides:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by a personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

MCL 500.3157 (emphasis added).

The dispute in this case centers on the plaintiffs' position that if the fee they charge does not exceed their customary fee – *i.e.*, the fee charged to patients without insurance – that it is

reasonable as a matter of law, and the carriers have no right to challenge it. That is the issue raised in the trial court on plaintiffs' motion for summary disposition. That is the issue that was decided by the Sixth Circuit Court of Appeals, and the one decided by the Court of Appeals. If the Court rejects plaintiffs' position on this issue, the decision of the Court of Appeals must be affirmed.

B. The Court Of Appeals Properly Held That No-Fault Insurers Are Permitted To Review A Customary Charge To Determine Whether That Charge Is Reasonable For The Services Rendered.

1. The Express Language Of The Statute Limits Providers To A Reasonable Charge.

The language of the Act is plain and unambiguous. Personal protection insurance benefits are payable for all "*reasonable* charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." MCL 500.3107 (emphasis added). Section 3157 is equally clear, authorizing a provider to charge "a *reasonable amount* for the products, services and accommodations rendered." MCL 500.3157 (emphasis added).

Plaintiffs argue that the only standard in the statute is the one contained in the second sentence of Section 3157, which states that the provider's charge "shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance." *Id.* Defendants agree that the Legislature has provided that a provider's fee cannot exceed the amount the provider customarily charges for like services. That does not mean, however, that the provider is permitted to charge a fee that is otherwise unreasonable. For example, a provider could have only three patients that have no form of health care insurance. [21] For each of those patients, the provider could charge $100,000 for his or her

[21] Of course, the percentage of patients who do not have insurance or are not

services to treat a minor injury resulting from an auto accident. While this charge would not exceed the charge the provider customarily charges for like services, it does not automatically mean that the charge is "reasonable."

If, as plaintiffs opine, the word "reasonable" in the statute has no meaning other than the "customary charge" to patients without insurance, the Legislature could have so stated. It did not elect to do so, as the Court of Appeals held:

> Plaintiffs' position that no-fault insurance carriers must pay the customary charges of health-care providers without regard to the reasonableness of the charges finds no support in the statute or case law. Rather than defining what it is "reasonable" charge, the clear and unambiguous language of the second sentence in MCL § 3157 simply places a maximum on what health-care providers may charge in no-fault cases. See *Hofmann*, *supra* at 114, 535 NW2d 529. The first sentence of § 3157 provides that a health-care provider may only charge a reasonable fee, while the second sentence "unambiguously provides that a health-care provider's charge for products, services or accommodations in cases covered by no-fault insurance '*shall not exceed* the amount customarily charge[s] ... in cases not involving insurance ..." *Id.* at 103, 535 NW2d 529 (emphasis changed). Thus, although § 3157 limits what can be charged, nowhere in that section does the Legislature indicate that a "customary" charge is *necessarily* a "reasonable" charge that *must* be reimbursed in full by the insurer.

Advocacy Org of Patient & Providers v Auto Club Ins Assoc, 257 Mich App 365; 375-766, 70 NW2d 569 (2003)(emphasis in original). The Sixth Circuit Court of Appeals held the exact same way, finding that the Legislature left the question of what constitutes a reasonable charge to the trier of fact. *AOPP*, 176 F3d 315, 320.

Because Sections 3107 and 3157 are unambiguous, they must be applied as written. As this Court stated in *Robertson*, *supra*, 465 Mich at 748:

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covered by programs such as Medicare, Medicaid, HMOs, PPOs, etc., where the fees are regulated by law or limited by contract, is extremely small. Thus, under plaintiffs' argument, the fees that they charge to this small percentage of their patients are the sole limitation on what plaintiffs can charge to no-fault insureds.

> When reviewing matters of statutory construction, this Court's primary purpose is to discern and give effect to the Legislature's intent. The first criterion in determining intent is the specific language of the statute. The Legislature is presumed to have intended the meaning it has plainly expressed, and if the expressed language is clear, judicial construction is not permitted and the statute must be enforced as written. Additionally, it is important to ensure that words in a statute not be ignored, treated as surplusage, or rendered nugatory. Unless defined in the statute, every word or phrase of a statute will be ascribed its plain and ordinary meaning.

Id. (emphasis added, internal citations omitted).

Consistent with the unambiguous language of the No-Fault Act, Michigan courts have held repeatedly that a provider's fee must be "reasonable," not just "customary." For example, this Court recently reviewed the origin and development of the No-Fault Act in *Kreiner v Fischer*, __ Mich __; 683 NW2d 611 (Docket No. 124120, decided July 23, 2004). In the very first paragraph of this section of the Opinion, the Court noted the impact of the passage on No-Fault on the payment of medical benefits:

> However, with the enactment of the no-fault act, 1972 PA 294, effective October 1, 1973, the Legislature abolished tort liability generally in motor vehicle accident cases and replaced it with a regime that established that a person injured in such an accident is entitled to certain economic compensation from his own insurance company regardless of fault. Similarly, the injured person's insurance company is responsible for all expenses incurred for medical care, recovery, and rehabilitation as long as the service, product, or accommodation is reasonably necessary and the charge is reasonable. MCL 500.3107(1)(a).

Kreiner, slip op at 3 (emphasis added). This Court had no difficulty discerning the statute's requirement that the providers' fee must be "reasonable" before an insurer (or patient) is required to pay it.

On this issue, the Court's recent description of the Act in *Kreiner* squares with its prior decision in *Nasser v Auto Club Ins Ass'n,* 435 Mich 33; 457 NW2d 637 (1990). In *Nasser*, the plaintiff was injured in an auto accident and claimed some $25,000 in medical expenses. The

defendant insurer disputed the reasonableness and necessity of the charges. The trial court granted summary disposition in favor of the plaintiff on liability, holding that defendant's argument went only to "damages." The Court of Appeals affirmed, but this Court emphatically reversed:

> Under this statutory scheme, an insurer is not liable for any medical expense to the extent that it is not a reasonable charge for a particular product or service, or if the product or service itself is not reasonably necessary. The plain and unambiguous language of § 3107 makes both reasonableness and necessary explicit and necessary elements of a claimant's recovery, and thus renders their absence a defense to the insurer's liability. In addition, the burden of proof on these issues lies with the plaintiff.

Nasser, 435 Mich at 49 (emphasis added).

The issue arose again in *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55; 535 NW2d 529 (1995), *lv den*, 452 Mich 870 (1996), where the insurer challenged whether the fee for performing x-rays was "customary." The Court's opinion makes clear that the tests for "customary" and "reasonableness" are separate tests:

> We note that the absence of contractual limitations in no-fault situations does not give health-care providers liberty to charge no-fault insurers any amount. In addition to the 'customary charge" limitation discussed above, §§ 3107 and 3157 also impose a statutory qualification of reasonableness, such that a no-fault carrier is liable only for those medical expenses that constitute a reasonable charge for the product or service. *Nasser, supra*, 435 Mich 49; *McGill, supra*, 207 Mich App 406.

Hofmann, 211 Mich App at 114 (emphasis added).[22] *See also LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 582, n3; 543 NW2d 42 (1995), *lv den*, 453 Mich 930 (1996) ("The

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[22] Plaintiffs and the amici cite to the *Hofmann* decision as purported support for their position. The issue in *Hofmann* was whether a "customary" charge should be evaluated based on the fee accepted by the provider for patients covered by insurance from Blue Cross Blue Shield. The issue of "reasonableness" was not challenged by Auto Club in the case. Moreover, the *Hofmann* court expressly held that a provider is limited to a "customary charge" and a "reasonable charge." *Id.*

Legislature has decreed that a health care provider cannot lawfully charge more than a reasonable amount for ... products, services, and accommodations.");[23] and *Spect Imaging Inc v Allstate Ins Co*, 246 Mich App 568; 633 NW2d 461 (2001) (must prove each expense is reasonable and necessary).

The plain statutory language and the case law interpreting it led the Sixth Circuit to conclude in this case that "reasonable" and "customary" are two distinct tests, each of which plaintiffs must satisfy:

> The [Hofmann] court specifically noted, however, that the "customary charge" and "reasonable" language in Mich Comp Law Ann § 500.3157 constituted separate and distinct limitations on the amount providers may charge with respect to auto accident victims covered by no-fault insurance (that is, the 'customary fee" charged by a particular provider does not define what a "reasonable fee" is); the court also noted that ACIA had not challenged the reasonableness of the particular charge at issue, basing its entire argument on what was, for that provider, a customary charge.

AOPP, 176 F3d 315, 320 (emphasis added). The Court of Appeals properly decided this issue the same way.

If the Court rejects plaintiffs' fundamental position that insurance carriers may not review medical invoices to determine whether the fees charged are "reasonable," then the decision of the Court of Appeals must be affirmed. *Knoper v Burton*, 383 Mich 62, 68; 173 NW2d 202 (1970) (where it appears that the errors could not have affected the result, the Court will not reverse). The defendants agree with this Court that "all reasonable expenses" for reasonably necessary

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[23] Plaintiffs criticize citation to the *LaMothe* case on the basis it did not consider whether the audit company used an acceptable method under the No-Fault Act to determine the fee at issue was unreasonable. (Plaintiffs' Brief, p. 24.) Defendants do not argue that *LaMothe* endorses a particular review methodology. *Lamothe* holds that a no-fault insurer is required to pay only the "reasonable" expenses for services provided. Plaintiffs admit the Court made this ruling, thereby undermining the entire premise of their case. *LaMothe* also holds that an insurer's review of medical bills is "compelled," a finding nowhere mentioned in plaintiffs' Brief.

medical services must be paid by the no-fault insurance carriers. *Kreiner, supra.* The flip side of this argument is also true. That is, no-fault insurance carriers have no obligation to pay fees that are unreasonable. As this Court previously held, "[u]nder this statutory scheme, an insurer is not *liable* for any medical expense to the extent that it is not a reasonable charge for a particular product or service, or if the product or service itself is not reasonably necessary." *Nasser v Auto Club Ins Ass'n*, 435 Mich 33, 48-49; 457 NW2d 637 (1990).

2. Plaintiffs' Interpretation Is Contrary To The Legislative Goal Of Containing The Cost Of Automobile Insurance Premiums.

As set forth *supra*, the language of the No-Fault Act is plain and unambiguous, and therefore, no judicial interpretation is required. Even if the statutes at issue were ambiguous, however (which they are not), Defendants' position is consistent with the legislative history of the No-Fault Act. This Court previously summarized the public policy considerations underlying the Act as follows:

> Enactment of the no-fault act was a major departure from prior methods of obtaining reparation for injuries suffered in motor vehicle accidents. The Legislature modified traditional tort principles of compensation by creating a comprehensive statutory scheme of reparation with the objective of providing assured, adequate and prompt recovery for certain economic losses arising from motor vehicle accidents. **We have also recognized a complementary legislative objective which is the containment of the premium costs of no-fault insurance.**

Davey v DAIIE, 414 Mich 1, 10; 322 NW2d 541 (1982) (emphasis added, citations omitted). The purpose of the No-Fault Act was not to give providers a blank check so that they could charge whatever fee they deemed appropriate without regard to whether the fee is "reasonable." "Insurance companies are not required to accept health care providers' unilateral decisions about what constitutes reasonable medical expenses, because to do so would undermine the Legislature's purpose in enacting §3107." *Spect Imaging, supra. See also, McGill v Auto Club*

Ins Ass'n, 207 Mich App 402, 408; 526 NW2d 12 (1994) (carriers required to review invoices for reasonableness); *Tebo v Havlik*, 418 Mich 350; 343 NW2d 181 (1984) (intent of the Act to make mandatory insurance coverage affordable to all motorists); and *Gooden v Transamerica Ins Corp of America*, 166 Mich App 793, 800; 420 NW2d 877, *lv den*, 431 Mich 862 (1988) ("The basic goal of the no-fault insurance system is to provide individuals injured in a motor vehicle accidents assured, adequate and prompt reparation for certain economic losses at the lowest cost to the individual and the system.").

Michigan law is clear that insurers are required to serve a cost-policing function under the No-Fault Act. No-fault insurers fulfill the statutory obligation to pay only a reasonable charge for reasonably necessary services by substantively review the services and fees of the providers. The *McGill* court summarized the obligation as follows:

> For the above reasons, we reject plaintiffs' argument that, pursuant to the no-fault act, defendants are obligated to pay the entire amount of plaintiffs' medical bills. Such an interpretation would require insurance companies to accept health care providers' unilateral decisions regarding what constitutes reasonable medical expenses, effectively eliminating insurance companies' cost-policing function as contemplated by the no-fault act. This result would directly conflict with the Legislature's purpose in enacting the no-fault system in general and § 3107 in particular. '[I]t is clear that the Legislature did not intend for no-fault insurers to pay all claims submitted without reviewing the claims for lack of coverage, excessiveness, or fraud.' *Lewis v Aetna Casualty & Surety Co*, 109 Mich App 136, 139; 311 NW2d 317 (1982).

McGill, 207 Mich App at 408 (emphasis added). *See also, LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577, 582; 543 NW2d 42 (1995), *appeal denied*, 453 Mich 927 (1996) (holding that an insurer's failure to perform such evaluations is a breach of the insurance policy and the No-Fault Act). Thus, McGill and LaMothe are consistent with the unambiguous statutory language and its

legislative history. A "reasonableness" standard exists and was designed to help contain the premium costs for no-fault insurers.

3. The Case Law Cited By Plaintiffs Does Not Support Their Claim That Providers Can Charge An Unreasonable Fee.

Plaintiffs cite *Mercy Mt Clemens Corp v Auto Club Ins Ass'n*, 219 Mich App 46; 555 NW2d 871 (1996), *lv den*, 456 Mich 877 (1997) as alleged support for their position (Plaintiffs' Brief, pp. 20-21.) In *Mercy*, the defendant insurance carrier sought discovery regarding what the plaintiff hospital accepted as payment in full when it billed various third party payers, such as Medicare, Medicaid, Blue Cross, and others. In support of its motion for discovery, the defendant argued that the "customary" fee was not what the provider billed in the absence of insurance, but what the provider accepted as payment in full from third-party payors. The Court of Appeals rejected this argument, ruling that the "customary" charge of the hospital was to be evaluated against the amount customarily charged to patients in cases not involving insurance, as specified in Section 3157 of the Act. *Mercy*, 219 Mich App at 52. Although the *Mercy* Court was not asked to consider what information was discoverable on the question of whether the fee was "reasonable" because that issue was not before it, the Court nevertheless noted:

> Section 3157 of the act prohibits medical care providers from charging more than a reasonable fee. Read in harmony, §§ 3107 and 3157 'clearly indicate that an insurance carrier need pay no more than a reasonable charge and that a health care provider can charge no more than that.' *McGill, supra*, p. 406, 526 NW2d 12. This statutory scheme serves the public policy that the existence of no-fault automobile insurance should not increase medical costs. *Id.*, pp. 407-408.

Mercy, 219 Mich App at 51, 52 (emphasis added, citations omitted). Thus, *Mercy* supports only defendants' position in this case.

Plaintiffs also point to *Munson Medical Center v Auto Club Ins Ass'n*, 218 Mich App 375; 554 NW2d 49, *lv den*, 453 Mich 959 (1996) (Plaintiffs' Brief, pp. 21-22.) The *Munson* case

involved Auto Club's use of the workers' compensation fee schedule to reimburse the hospital for care rendered to no-fault patients. The only issue presented in that case was the meaning of the statutory term "customary charges." *Munson*, 218 Mich App at 382 ("The critical issue in this case is what the statutory term 'customary charges' means."). The plaintiffs state, without citation, that the defendant in *Munson* claimed that the hospital's charges were unreasonable. (Plaintiffs' Brief, p. 21.) This statement is plainly wrong. The issue in *Munson* was the standard against which a "customary" charge was evaluated. *Id.* Although the Court was not asked to rule on what constituted a "reasonable fee," the Court nonetheless noted that a "statutory qualification of reasonableness limits the amount that must be paid by a no-fault carrier for covered medical expenses." *Id.*, 218 Mich App at 384. Therefore, neither *Mercy* nor *Munson* supports the position advocated by plaintiffs here that the statute permits them to charge an unreasonable fee.

Plaintiffs also cite to *Johnson v Michigan Mut Ins Co*, 180 Mich App 314; 446 NW2d 899 (1989). (Plaintiffs' Brief, pp. 23-24.) The issue in *Johnson* was not the reasonableness of the hospital's charges or the necessity of the services. Instead, the only issue was whether the fee amounts accepted by the hospital from Medicaid constituted the hospital's customary charge. *Id* at 321. The court concluded that a "customary" charge was evaluated by charges made to other injured persons "in cases not involving insurance." The case never discussed the test for reasonableness, as the issue was not contested in that case.

The key point that plaintiffs ignore in their analysis is that "reasonableness" is one of the criteria in the statutes against which their fees must be measured. The Court of Appeals here properly held that it could not adopt an interpretation of the statute that renders this term meaningless, and essentially reads it out of the statute, as plaintiffs propose. 257 Mich App at

375-79) *In re MCI Telecommunications Complaint*, 460 Mich 396, 414; 596 NW2d 164 (1999).[24] That decision was correct and should not be disturbed by this Court.

The amici rely on some additional cases, never cited by plaintiffs, which add nothing to the analysis. For example, *Hicks v Citizens Ins Co*, 204 Mich App 142; 514 NW2d 511 (1994), cited at length by MSMS at pages 7-8, has nothing to do with the situation presented here. The issue in *Hicks* was whether the plaintiff had "incurred" medical expenses that were recoverable, not whether the underlying charges were reasonable. *Id.* at 146-147.

The case of *Bombalski v Auto Club Ins Ass'n*, 247 Mich App 536; 637 NW2d 251 (2001), also cited by the amici, is equally inapplicable. Like *Hicks*, the issue in *Bombalski* was whether the charges had been "incurred" by the plaintiff, not whether the charges were "reasonable." As the Court expressly stated:

> Because the parties challenge neither the reasonable necessity of plaintiff's medical care nor the reasonableness of the health care providers' charges for these services, our decision focuses on the statutory meaning of "incurred." *Moghis v. Citizens Ins. Co. of America*, 187 Mich. App. 245, 247, 466 N.W.2d 290 (1990)(noting that the three requirements under subsection 3107(1)(a) include (1) the expense must be incurred, (2) the expense must have been for a product [or], service ... reasonably necessary for the injured person's care, ... and (3) the amount of the expense must have been reasonable").

247 Mich App at 254 (emphasis added). The Court concluded that amounts in excess of those paid to the hospital by Blue Cross, and accepted by the hospital as payment in full, were not "incurred" within the meaning of Section 3107(1) and, therefore, the no-fault carrier had no obligation to pay them. *Id* at 546. The Court distinguished the issues presented in *Munson* and

[24] The MSMS amicus argues that defendants' position reads the word "customary" out of the statute. Defendants argue no such thing. If a provider is charging the no-fault carriers more than the provider charges to the other patients who do not have insurance, the Legislature has decreed that the excess amount is not recoverable. This standard, in addition to the reasonableness evaluation, continues to apply.

Hofmann, saying those cases involved a different statutory section, as each interpreted the term "customary charges" within MCL 500.3157, and not the proper interpretation of Section 3107. *Id* at 256, n 3 This portion of the Court's footnote is omitted from the quote offered by MSMS from the case. (MSMS Brief, p. 8.)

MSMS also argues that *Kallabat v State Farm Mut Auto Ins Co*, 256 Mich App 146; 662 NW2d 97 (2003), supports its position that a provider is not required to offer evidence that expenses are reasonable in order to prevail. (MSMS Brief, p. 13.) This is a gross mischaracterization of that case. In *Kallabat,* it was undisputed that the plaintiff insured had the burden to establish that the expenses were reasonable and reasonably necessary. The issue was whether the insured was required to submit direct evidence of reasonableness, or whether the plaintiff could rely on the preponderance of the evidence, including circumstantial evidence and permissible inferences of reasonableness. On this question, the Court held that Section 3107 does not require "direct" evidence from the treating physician that the expenses incurred were both reasonable and reasonably necessary to prevail. Like any other civil case, the:

> "[J]ury is entitled to consider all the evidence introduced by the plaintiff to decide whether the plaintiff has proved by a preponderance of the evidence that the expenses were reasonable and necessary. M Civ JI 3.09. Thus, direct and circumstantial evidence, and permissible interferences therefrom, may be considered by the jury to determine whether there is sufficient proof that the expenses were both reasonable and necessary."

256 Mich App at 151-52. *Kallabat* is consistent with the Court of Appeals' *AOPP* decision, as both require the plaintiff to bear the burden of proof in the determination of reasonableness. *Kallabat* simply discusses the types of proof that can be used to satisfy that burden.

The amici describe the No-Fault Act as the "rule book" for deciding questions relating to the payment of personal protection benefits. (MSMS Brief, p. 14.) On this statement, all parties agree. Where the parties diverge is the amici's claim that the *AOPP* decision somehow engrafts

new limitations on the right of providers to recover their fees. The requirement that providers charge reasonable fees has been in the No-Fault Act since its passage. The *AOPP* decision does not "give deference to what the insurer will pay" or "confer[] power upon insurers and limitations upon providers" that go beyond the plain language of the Act. (MSMS Brief, pp. 13, 16.) Instead, the decision stands for the well-established proposition that a statute should be interpreted in accordance with its plain language, and that neither the providers or the insurers have the unilateral right to dictate what charges are per se reasonable.[25]

Finally, MSMS argues that it would make no sense for the Court of Appeals to prohibit the use of maximum fee schedules as "violative" of the "customary" charge language, but permit such schedules to be imposed under the "reasonable" charge requirement. (MSMS Brief, p. 9.) This completely misstates the Court's ruling, which does not impose any fee schedules for the purpose of determining when a charge is reasonable. Therefore, the premise of the entire argument is wrong.

C. The Prior Efforts To Amend The No-Fault Act Are Irrelevant Here.

Plaintiffs and the amici argue that the insurers failed in their efforts to have fee schedules placed into the No-Fault Act, and should not be permitted a de facto amendment of the statute. The insurers do not dispute that certain amendments sought by some members of the insurance industry were not enacted. Some of those amendments would have put into place fee schedules that would have greatly reduced disputes between the parties as to what constitutes a

[25] MSMS also asserts, without any factual foundation, that the decision leaves providers with no practical recourse on disputed fee issues. (MSMS Brief, p. 17.) This is simply not true. The affidavits filed in support of Defendants' Motion to Dismiss and its Brief Opposing Class Certification outline the many types of informal dispute resolutions offered by the insurers to resolve any fee issues in a cost effective manner. (*See e.g.*, Neilson Affidavit, App. pp. 160-63b.) Less than two percent of bills submitted through Review Works' reconsideration process remain disputed. (Mateja Deposition, pp 78-79, App. p. 54b.) The undisputed evidence, as demonstrated by those same affidavits, shows that providers do in fact file suit when they believe that they have been underpaid. (*See* Ittner Affidavit, App. pp. 116b-145b).

"reasonable" fee. Because those proposed amendments were not enacted, the insurance industry incurs substantial costs every year in reviewing individual invoices for reasonableness, disputing those invoices that it believes are not reasonable, and creating extensive data bases used to compare provider's charges with each other. These costs could have been eliminated if some of the proposed amendments had passed.

If the Court of Appeals had adopted a fee schedule through its Opinion, this would be a different case. However, it did not do so, instead holding that the jury must ultimately determine whether a particular fee is reasonable. Neither party has the unilateral right to decide reasonableness. While the parties may disagree with the Legislature's choice to not reform the No-Fault Act, this disagreement does not warrant deviating from the current statute's language. *Mayor of the City of Lansing v Mich Pub Serv Comm*, 470 Mich 154, 161; 680 NW2d 840 (2004).

D. Plaintiffs' Citation To The Laws Of Other Jurisdictions Only Demonstrates That Michigan's No-Fault System Is Unique, And Does Not Establish Mandatory Guidelines To Be Used When Determining Reasonableness.

At pages 27 through 31 of their Brief, plaintiffs embark on a dissertation of the laws of various other jurisdictions and how those jurisdictions treat the payment of medical fees. Defendants agree that many other jurisdictions, unlike Michigan, have adopted statutes that contain a precise standard against which fees can be measured. As plaintiffs concede, however, this is not Michigan law, and our statute has no built-in standard other than "reasonableness" and "customary" against which the providers' fees can be measured. Defendants agree that this situation can only be remedied by the Legislature. It is the job of the Legislature, not the courts, to address the results of the legislative trade-offs that have been made[26] *See, People v McIntire*,

[26] As noted in the concurrence filed by Judge Fitzgerald in the Court of Appeals' decision in this case, there would be greater precision to the process if the Legislature adopted a

461 Mich 147, 155-156; 599 NW2d 102 (1999) (plain language of the statute controls even if the results are "absurd"). Until the Legislature decides to provide a standard other than the one currently contained in Sections 3107 and 3157, all the parties are required to leave the determination of reasonableness to the courts.[27]

E. The Plaintiffs' Contention That There Is An Unconstitutional Delegation Of Power Because Defendants Review Medical Invoices Is Not Pled In The Complaint And Fails As A Matter Of Law.

Plaintiffs' Complaint purports to assert a claim under the Michigan Constitution for impairment of contracts. In Federal Court, plaintiffs shifted their claim, arguing an alleged violation of the Due Process Clause of the United States and Michigan Constitutions. On remand, plaintiffs attempted to shift again, asserting that the review of medical bills results in an unconstitutional delegation of power. (Dkt. # 162.) Of course, this argument did not appear anywhere in the Complaint, was not referred to in the statement of questions presented, and thus was not properly before the Court of Appeals.[28]

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fee schedule rather than using the requirement of reasonableness. This lack of precise certainty, however, does not make the statute unenforceable or require a judicial amendment of the statute. That is the job of the Legislature.

[27] In this section, plaintiffs assert that defendants are using various fee schedules and rate tables for the determination of what is reasonable. There is no support for this assertion in the record. If plaintiffs believe that one of the individual carriers or review companies are denying an invoice on this basis, that affected plaintiff can challenge the level of that reimbursement.

[28] Plaintiffs argue that the issue appears in their Complaint at paragraph 124. (Plaintiffs' Brief, p. 33.) As the Court will note upon its review, there is in fact no such reference in that paragraph. Plaintiffs also point to two of their prior briefs on unrelated issues. Putting an argument before the trial court is not the same as properly presenting it for decision so that it can be decided by the lower court. *See e.g.*, *Wallad v Access BIDCO, Inc*, 236 Mich App 303, 309; 600 NW2d 664 (1999)(court will not consider issue not raised in the statement of questions involved); *Mudge v Macomb County*, 458 Mich 87, 104-05; 580 NW2d 845 (1998)(parties cannot leave the issue to the Court to decipher on appeal). That the Court of Appeals declined to address this specious claim does not justify reversal by this Court.

If the Court considers plaintiffs' unconstitutional delegation of power argument even though (i) it was not pled, and (ii) the law of the case is that there is no state action at issue,[29] defendants were entitled to summary disposition of the issue. "Statutes are presumed to be constitutional, and courts have a duty to construe a statute as constitutional unless its unconstitutionality is clearly apparent. ... A party challenging the facial constitutionality of a statute must establish that no circumstances exist under which it would be valid." *Stevenson v Reese*, 239 Mich App 513, 517; 609 NW2d 195 (2000).

Plaintiffs' constitutionality argument rests on the assertion that defendants' interpretation of the No-Fault Act is unconstitutional because the Legislature did not delegate power to defendants to regulate the charges of medical providers. (Plaintiffs' Brief, pp. 34-36.) Of course, this misstates defendants' position entirely. Defendants are required by statute to pay only those fees that are reasonable and do not exceed the provider's customary charge in the absence of insurance, and that they may review medical invoices in order to comply with these statutory limitations. In the event that a defendant disagrees with a provider on whether the fee is reasonable or customary, the defendant is obligated to pay the amount that it does consider reasonable and customary. The disputed difference between the parties can be resolved between

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[29] Regardless of which constitutional argument plaintiffs now want to advance, however, plaintiffs are required to demonstrate that the act of reviewing medical invoices is a "state action" subject to constitutional review. In the Complaint, plaintiffs attempt to make this link by citing *Shavers v Attorney General*, 402 Mich 554; 267 NW2d 72 (1978), *cert den*, 442 US 934 (1979), for the proposition that the operation of the Michigan No-Fault Act "result[s] in a sufficiently close nexus between the State and the regulated entity (the insurance industry) so that the actions of the regulated entity [can] fairly be treated as that of the state itself." Complaint, at ¶ 137. Judge Bell of the Western District disposed of this argument by holding that Shavers does not turn every action by a no-fault insurer into a state action for due process purposes. He further held that the review of medical bills by insurers lacked a sufficiently close nexus to the state that the actions by the insurers could be deemed to be state action. Opinion, p. 10. The plaintiffs did not appeal this holding to the Sixth Circuit Court of Appeals, making it the law of the case. *McKane v Lansing*, 244 Mich App 462, 466; 625 NW2d 796, *lv den*, 465 Mich 878 (2001).

them, or either party can file an action to seek a determination that their position is correct. Defendants ***do not claim*** that they can unilaterally dictate prices or prevent providers from collecting medical fees. Rather, defendants claim that they are entitled to undertake the type of review expressly approved in *McGill* and *LaMothe*. Thus, defendants have not been "delegated" any power to regulate charges by the Legislature or the Court of Appeals.[30]

Furthermore, even if Sections 3107 and 3157 could be construed to be a "delegation of power" to the insurers, the standards are as reasonably precise as the subject matter requires. The fact that the statute does not provide standards as to what constitutes a "reasonable" fee does not make it unconstitutional.[31] Rather, the use of the term recognizes that the reasonableness of a fee in any particular circumstance will vary depending on the particular facts presented.

Although the word "reasonable" "does not mean exact and is not subject to mathematical computation with scientific exactitude," it has been interpreted for decades in Michigan by courts and by juries and provides sufficient legislative guidance. *Atlas Valley Golf & Country Club, Inc v Goodrich,* 227 Mich App 14, 26; 575 NW2d 56 (1997). For example, due process always requires proof "beyond a reasonable doubt of all elements of a crime." *Duffy v Foltz*, 425 Mich 457, 467; 390 NW2d 620 (1986). Therefore, every criminal case requires a determination by the jury on "reasonable doubt." The word "reasonable" occurs repeatedly throughout the Standard

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[30] Plaintiffs cite to *Blue Cross & Blue Shield of Mich v Governor*, 422 Mich 1; 367 NW2d 1 (1985), as alleged support for their position. The *Blue Cross* decision is wholly inapplicable. In that case, the Court criticized the Blue Cross Reform Act because the commissioner was directed to "approve" or "disapprove" the proposed risk factors without any standards. *Id* at 52-55. In this case, however, the Legislature has promulgated a standard – the fee must be reasonable and cannot exceed the fee customarily charged to those without insurance. That standard is as reasonably precise as the subject matter requires.

[31] As noted by the Michigan Supreme Court, the precision required of the standards will depend on the complexity of the subject and will vary from case to case. *Blank v Dep't of Corrections*, 462 Mich 103, 125; 611 NW2d 530 (2000).

Jury Instructions as a standard to be applied by a jury.[32] Even the Michigan Constitution is to be interpreted using the interpretation that "reasonable minds, the great mass of the people themselves, would give it." *House Speaker v Governor*, 443 Mich 560, 577; 506 NW2d 190 (1993).

This Court was previously asked to opine on the constitutionality of language in the No-Fault Act to determine whether it provided standards sufficient for legal interpretation. In the case of *In re Requests of Governor & Senate on Constitutionality of 1972 PA 294*, 389 Mich 441; 208 NW2d 469 (1973), the Court held that the phrases "serious impairment of body function" and "permanent serious disfigurement" as used in the Act provide standards sufficient for legal interpretation. The rationale for the Court's ruling applies with equal force here:

> This Court holds that such phrases are capable of legal interpretation and, indeed, that juries or judges sitting without juries frequently have and do interpret comparable phrases bearing upon various facets of the law. Such findings result from denominated fact questions and thus are within the exclusive province of the triers of fact. Only when interpretation approaches or breaches permissible limits does it become a question of law for the Court. Such questions must be approached on a case by case basis. ...
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> ***
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> Phrases comparable to 'permanent serious disfigurement' have confronted courts over the years and there has been no apparent reluctance to construe the terminology. A reading of the Standard Jury Instructions for civil cases indicates further the wide range of

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[32] For example, a jury is instructed that it may take into account whether any particular evidence "seems reasonable and probable." SJI2d 3.11. Negligence is defined as a failure to do something that a "reasonably careful person would do, or the doing of something that a reasonably careful person would not do." SJI2d 10.02. Juries award first-party no-fault benefits based on "allowable expenses," which are defined to be "all reasonable charges incurred for reasonably necessary products, services, and accommodations. ..." SJI2d. 35.01. In most cases, the jury can determine the amount of damages to be awarded to "reasonably, fairly and adequately" compensate the injured party. SJI2d 50.01.

> questions which our Court permits triers of fact to decide. For example, in negligence cases the jury is permitted to determine 'what a reasonably careful person would do or not do' under the circumstances (10.01). It is permitted to determine questions of 'contributory negligence' (11.01), 'willful and wanton misconduct' (14.0-2), 'gross negligence' (14.03), 'proximate cause' (15.01) and 'intervening negligence' or 'outside force' (15.05, 15.06).
>
> The jury must also decide the amount of damages to be awarded in order 'reasonably, fairly and adequately' to compensate the injured party (30.01). The jury may decide if the injury is 'continuing' or 'permanent" (30.01). The jury may determine 'the reasonable expenses of necessary medical care, treatment and services' (30.05) and 'the loss of earning capacity' (30.06). In wrongful death actions, the jury may determine awards for losses of 'parental training and guidance' or 'society and companionship.'
>
> Clearly the subject phrases 'serious impairment of body function' and 'permanent serious disfigurement' as used in § 3135 of this act are comprised of no less commonly used or understood words of the English language, nor is the language presently before the Court less precise than that which has been adopted to express other standards for determining tort liability. The phrases are within the province of the trier of fact and are sufficient for legal interpretation.

389 Mich at pp 477-481 (footnotes omitted, emphasis added).

This is not a case where the Legislature has delegated to insurers the sole power to determine what is "reasonable," and thus the arguments by plaintiffs simply miss the point. Rather, it is a case where the Legislature instructed providers to charge a "reasonable" fee and insurers to pay a "reasonable" fee. If the parties disagree on whether the amount of the fee is reasonable, or the methodology used by the insurer to reach its proposed determination of a reasonable fee, the term "reasonable" has a sufficient history in Michigan jurisprudence to be within the province of the trier of fact and sufficient for legal interpretation.

II. THE COURT OF APPEALS APPROPRIATELY STATED IN DICTA THAT THE METHODOLOGY USED BY SOME INSURERS AND ONE REVIEW COMPANY TO EVALUATE CHARGES FOR REASONABLENESS IS NOT BARRED AS A MATTER OF LAW, AND IN ANY EVENT, THE DICTA DOES NOT SUPPORT REVERSAL OF THE DECISION.

Because the plaintiffs and the amici have no real response to the Court of Appeals' holding on the unambiguous statutory language, they misconstrue a single passage in that opinion, and then spend the rest of their briefs attacking the straw man they have created. All the amici and the plaintiffs argue that the Court of Appeals erred by "adopting" the 80th percentile "test". Despite these protestations, the Court of Appeals did not rule that the 80th percentile method utilized by Review Works and some insurers to review medical bills is a dispositive indicator of reasonableness. Nor did the Court of Appeals "adopt" a fee schedule that can be used or enforced by the insurers as a matter of law. The Court left the ultimate determination of whether a fee is reasonable exactly where the Legislature placed it in the event of a dispute: with a jury. The following passage from the Court's opinion makes this clear:

> Instead, we hold that the statute requires that an insurer only pay on behalf of the insured a "reasonable" charge for the particular product or service. However, the Legislature has not defined what is "reasonable" in this context, and, consequently, insurers must determine in each instance whether a charge is reasonable in light of the service or product provided. It may be that a health-care provider's "customary" charge is also reasonable given the services provided, while at other times the "customary" charge may be too high, and thus unreasonable. Either way, the trier of fact will ultimately determine whether a charge is reasonable. *Nasser, supra* at 55, 457 NW2d 637.
>
> We will not attempt to delineate the permissible factors for determining what is "reasonable," because it is not necessary to do so in resolving plaintiffs' arguments. Defendant in this case have not refused to pay health-care benefits due plaintiffs. To the contrary, defendants paid what they believed to be the reasonable charges incurred for reasonably necessary products, services, and accommodations for their insured's care. Under the foregoing case law, defendants are allowed to pay the reasonable amount and contest the claim under the act without penalty where a reasonable

> dispute exists regarding the amount of benefits owing. *LaMothe, supra* at 581-82; 543 NW2d 42; *Lewis v Aetna Cas & Surety Co*, 109 Mich App 136, 139, 311 NW2d 317 (1981). The fact that the amount paid is less than the amount the health-care provider charged does not violate the act where the amount paid is based on a proper determination of what is reasonable and the insurer will defend and indemnify the insured if the health-care providers sues the insured for the balance. *LaMothe, supra.*

257 Mich App at 379-80. (footnote omitted, emphasis added). It is clear from reading the actual opinion that the Court of Appeals did not predetermine the issue of reasonableness.

With regard to the 80th percentile "test" specifically, the Court of Appeals simply noted that the evaluation methodology is not precluded by the plain language of the statute. This is because the statute does not authorize or preclude any particular methodology to make a reasonableness determination. 257 Mich App at 380. Under the Court's holding, if a provider is unhappy with the payment received on an invoice, the provider is not barred from filing suit and challenging the insurer's rejection of the charge, even if the charge exceeds what 80 percent of his or her colleagues are charging for the same service. The Court has ruled only that the methodology is not precluded by law – not that it is the appropriate test for reasonableness in every instance. If a provider is charging more than 80 percent of his or her peers for the same service, the provider may avail himself or herself of the appeal mechanisms provided by the various insurers and review companies, and/or may litigate whether in his or her individual case the fee is still reasonable. Nothing in the Opinion foreclosures this approach.[33]

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[33] The plaintiffs' Brief takes issue with whether all the carriers are using the 80th percentile formula, citing to a decade old letter from Manageability, who has never claimed to use that formula. (Plaintiffs' Brief, p. 26.) To defendants' knowledge, Manageability has never used the "80th percentile" in its review of records, and thus the letter is completely irrelevant to deciding the legal issue presented here. The fact that different carriers and review companies use different means of evaluating reasonableness is precisely why the lower court and Court of Appeals held that class certification was inappropriate – a conclusion not challenged by Plaintiffs here. If, in an individual case, the provider does not like the determination of the carrier, he or she can pursue a claim against the carrier for the difference.

Plaintiffs address this argument only in a footnote, saying that the Court of Appeals "clearly approved" of the database used by Auto Club and Review Works. (Plaintiffs' Brief, p. 25.) This statement, as set forth above, is an inaccurate conclusion to draw from the Court's opinion, which simply states that it is not rejecting the database as a matter of law, just as it does not adopt the database as a matter of law for the determination of whether the charge is reasonable.

The amici argue that the 80th percentile "test" is "arbitrary and capricious" and that the Opinion impermissibly amends the No-Fault Act. (MSMS Brief, pp. 12-13; MHA Brief, pp. 7-12.) Once again, the fallacy underlying this argument is that the Court "adopted" the 80th percentile "test" in its decision. This premise is faulty and contrary to the express language of the Court's opinion. The Court held only that the methodology used by some insurers and one review company to make an initial evaluation of whether a claim is reasonable is not barred by the statute. The Court of Appeals has not overridden the providence of the jury to decide the issue on a case-by-case basis, which is what the plain language of the Act requires.[34]

As noted in the Concurring Opinion, the parties may have benefited if the Legislature had adopted a fee schedule to eliminate disputes over whether a particular charge is reasonable. 257 Mich App at 385-86. As the amici argue and Defendants admit, the Legislature ultimately did not adopt any such fee schedule. The Legislature did, however, leave the requirement of a reasonable charge in the statute, and that provision must be read in a way to give it meaning. Ignoring this statutory requirement completely – as urged by the amici who want to reference

[34] With great glee, the amicus filed by MSMS quotes from counsel's argument during the motion for class certification as to why each individual lawsuit will require individualized proofs. (MSMS Amicus, pp. 22-24.) The quotations accurately describe defendants' position at the time, and now. Defendants do not claim that if they accept the recommendation of Review Works, that they will not be required to defend their position if a provider disagrees with the insurer's determination of reasonableness.

only a customary charge – reads the reasonableness requirement out of the statute. Opinion, p. 7.[35]

Finally, even if this Court were to disagree with the appropriateness of the methodology used by Review Works, that conclusion does not warrant reversal of the decision by the Court of Appeals. The legal question that both parties asked the trial court to decide was whether the insurers must pay the amount that the provider charges as his or her "customary" fee to those patients without insurance, without separately considering whether the amount charged was "reasonable." The holding of the Court of Appeals on this legal issue is correct and should be affirmed.

Moreover, plaintiffs' prediction that a flood of lawsuits will result is simply not supported by the evidence. (Plaintiffs' Brief, p. 32.) According to plaintiffs, the insurers have been reviewing their medical invoices for over a decade. The courts have not been flooded with balance-billing lawsuits, despite the review of the providers' bills. The bottom line is that the No-Fault Act does not mandate a particular methodology to be used by the insurers or review companies to determine whether a fee is reasonable. Both the Sixth Circuit and the Court of Appeals recognized this. Their conclusions, perfectly consistent with the plain language of the statutes and the legislative history, should not be disturbed.

[35] Ironically, MSMS admits that the plain language of the statute must be followed and that statutory changes require legislative action. (MSMS Brief, p. 9.) What MSMS fails to do, however, is harmonize this position with its argument that "reasonableness" means the same thing as customary, and that the Legislature somehow did not understand that the two words had different meanings. Why use two different terms in the legislation, with different common and legal meanings, if the two terms mean the exact same thing?

III. THE COURT OF APPEALS' DECISION IS NOT CONTRARY TO THE PRINCIPLES OF MEDICARE REIMBURSEMENT.

The MHA makes the absurd argument that the *AOPP* decision is contrary to the Medicare reimbursement program. The crux of the argument is at the bottom of page 11 and carries over to page 12, where the MHA contends that because they would have different charges applicable to no-fault insureds, they would need to develop a second fee or "charge schedule." As an initial matter, a "second charge schedule" needs to be developed by the hospital only if existing fees are unreasonable. If the fees on its existing schedules are reasonable, the hospital does not need a new schedule.

Second, as the MHA Brief admits, the amount that the hospitals charge for their fees and what they collect are two different questions under the Medicare reimbursement statutes. A provider can accept whatever fee it wants, or can challenge the amount paid by any payor. Thus, if a hospital's charges are not paid in full because a particular insurer contends that the charges are not reasonable, the hospital does not violate the Medicare reimbursement statute by deciding not to challenge the amount it actually receives in a particular case.

Moreover, agreements between individual insurers and hospitals are permitted by the Medicare system, even if it results in different fees from the "fee schedule" submitted by the hospital under Medicare. (*See* MHA Brief, p. 10; Provider Reimbursement Manual § 2604.3.) As a result, hospitals and no-fault carriers are free to enter into their own contracts setting a fee, and that agreement falls outside of Medicare. As set forth in the Counterstatement of Facts, the defendant carriers have entered into contracts with a number of hospitals, and none of the named plaintiffs here are hospital.

Third, there is nothing in the Medicare act that permits a hospital to charge an unreasonably high fee. Charges to Medicare for a specific service are required to be "related

consistently to the cost of the services." Provider Reimbursement Manual § 2202.4. Therefore, whether a hospital is treating a "regular" patient or a no-fault patient, it is subject to statutory limitations designed to prevent unreasonable fees.

Finally, the alleged "harm" of creating a second fee schedule, even if it occurred, is a legislative issue, not one for the courts.

IV. THE LOWER COURT PROPERLY DISMISSED PLAINTIFFS' CONSPIRACY CLAIM.

Plaintiffs' conspiracy argument depends entirely on the Court accepting their view of the proper interpretation of the No-Fault Act. If that interpretation fails, so does the conspiracy claim as defendants do not act unlawfully by reviewing medical invoices for reasonableness. (Plaintiffs' Brief, pp. 36-37.) For the reasons set forth *supra*, defendants' actions are not unlawful and thus cannot form the basis of a conspiracy claim. Moreover, dismissal of plaintiffs' conspiracy claim was proper because (1) there is no actionable tort underlying the claim, and (2) even if there is an actionable tort, the conspiracy claim has not been pled with sufficient particularity.

A. Absent The Existence Of An Underlying Actionable Tort, The Civil Conspiracy Claim Fails To State A Claim Upon Which Relief Can Be Granted.

In Michigan, a conspiracy is defined as:

> ...a combination of two or more persons, by some concerted action, to accomplish a criminal or unlawful purpose, or to accomplish a purpose not unlawful by criminal or unlawful means.

Fenestra Inc v Gulf American Land Corp, 377 Mich 565, 593; 141 NW2d 36 (1966); *Cousineau v Ford Motor Co*, 140 Mich App 19, 36-37; 363 NW2d 721, *cert den* 474 US 971 (1985). Despite the necessity of proving an agreement, the agreement does not, in itself, constitute an actionable claim. A claim for conspiracy "may not exist in the air; rather, it is necessary to prove

a separate, actionable, tort." *Early Detection Center, PC v New York Life Ins Co*, 157 Mich App 618, 632; 403 NW2d 830 (1986); *Admiral Ins Co v Columbia Casualty Ins Co*, 194 Mich App 300, 318; 486 NW2d 351 (1992), *lv den*, 442 Mich 917 (1993). In short, "there is no such thing as a civil action for conspiracy," and Plaintiffs must establish that the alleged co-conspirators committed an underlying wrong. *Roche v Blair*, 305 Mich 608, 616; 9 NW2d 861 (1943); *Magid v Oak Park Racquet Club Assoc*, 84 Mich App 522, 529; 269 NW2d 661 (1978).

Plaintiffs allege that Defendants "agreed to try to interfere with existing contractual relationships and existing business relationships or expectancies between Plaintiff health care providers and their patients." *See* Complaint, at ¶ 154. For the reasons set forth *infra*, the tortious interference claims must fail as a matter of law. Once the tortious interference claims fail, then the conspiracy claim must fail as there is no underlying wrong upon which the conspiracy claim can be based. Accordingly, summary disposition of the conspiracy claim was proper.

B. Plaintiffs' Conspiracy Claims Are Conclusory Only And Are Not Founded Upon Assertions Of Supporting Facts.

Even if there were an underlying tort which survives summary disposition, the conspiracy claim would still fail because it was not sufficiently pled. MCR 2.111(B)(1), the general pleading rule, mandates that a complaint contain "the facts" on which the plaintiff relies in stating a cause of action. "The law is well settled that the mere statement of the pleader's conclusions, unsupported by allegations of fact upon which they are based, will not suffice to state a cause of action." *Pursell v Wolverine-Pentronix, Inc*, 44 Mich App 416, 422; 205 NW2d 504 (1973). Conspiracy claims are no exception.

In *Chilton's, Inc v Wilmington Apt Co*, 365 Mich 242; 112 NW2d 434 (1961), the plaintiff sued to set aside certain deeds for a lot that the plaintiff previously owned. Because the

plaintiff failed to record the deed, the lot was sold due to delinquent taxes. The plaintiff sued the seller, the seller's agents, and subsequent purchasers of the lot alleging, among other things, a conspiracy to conceal the tax delinquencies from the plaintiff. This Court affirmed the dismissal of the complaint, holding that the plaintiff failed to allege facts tending to show that the defendants entered into any agreement to injure the plaintiff; no affirmative act on the part of the defendants was alleged, and the complaint did not allege facts from which the duty to advise the plaintiff of its delinquency might arise. As stated by this Court, "We are in accord with the holding of the circuit judge that the bill of complaint filed in the case failed to allege facts sufficient to establish a cause of action. Mere conclusions and statements not supported by factual averments were not sufficient to that end." *Id.* at 250-251. *See also Sankar v Detroit Bd of Educ*, 160 Mich App 470; 409 NW2d 213 (1987) (holding that mere conclusions cannot act as supporting facts for a conspiracy claim); and *Cowan v Federal Mogul Corp*, 86 Mich App 619, 621-22; 273 NW2d 487 (1977) (affirming dismissal where plaintiffs failed to allege facts supportive of the conspiracy claim).

Here, the Complaint fails to state what the alleged "agreement" is, whether there are multiple agreements, who the parties to the agreements are, the terms of the alleged agreements, or anything else of sufficient particularity for Defendants to identify the nature of the conspiracy. Under Michigan law, this is insufficient to state a conspiracy claim.

V. THE LOWER COURT PROPERLY DISMISSED PLAINTIFFS' CLAIM FOR TORTIOUS INTERFERENCE WITH CONTRACTUAL AND BUSINESS RELATIONSHIPS.

The tortious interference counts were properly dismissed because (1) plaintiffs failed to allege a per se wrongful act, or a lawful act done with malice and unjustified in law, (2) defendants have a legitimate business interest in monitoring health care providers' bills, and thus cannot be liable for tortious interference, and (3) plaintiffs have no valid contractual right to

receive whatever fees they want when treating no-fault patients, and thus cannot sue for tortious interference.

A. Plaintiffs Failed To Allege A Per Se Wrongful Act Or A Lawful Act Which Was Not Justified By Law.

Under Michigan law,

> [O]ne who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another.

Prysak v R L Polk Co, 193 Mich App 1, 12; 483 NW2d 629 (1992) (citations omitted). "A wrongful act per se is an act that is inherently wrongful or an act that can never be justified under any circumstances." *Id.* at 12-13. For a lawful act to be actionable, plaintiffs must allege that the defendant acted with malice, that the action was unjustified, and that the interference was "improper." To be "improper," the defendant's actions must be "illegal, unethical, or fraudulent." *Trepel v Pontiac Osteopathic Hosp*, 135 Mich App 361, 374; 354 NW2d 341 (1984), *lv den*, 422 Mich 853 (1985) (affirming summary disposition of tortious interference count). Moreover,

> [A] plaintiff must demonstrate, with specificity, affirmative acts by the interferer which corroborate the unlawful purpose of the interference.

Michigan Podiatric Medical Assoc v National Foot Care Program, Inc, 175 Mich App 723, 736; 438 NW2d 349, *lv den*, 453 Mich 959 (1989) (citing *Feldman v Green*, 138 Mich App 360, 378; 360 NW2d 881 (1984)).

Plaintiffs' tortious interference claim is based on allegations that Defendants have advised patients/insureds (i) that providers are permitted under the Act to charge only reasonable amounts for necessary procedures, (ii) that the insurers would cover all charges meeting these criteria, and (iii) that insurers would defend patients/insureds in the event a provider sued to

recover reimbursements for charges that the insurers determined not to be reasonable or necessary. These activities are not "illegal," but legally required. As noted *supra*, no-fault insurers fulfill their statutory obligation by substantively reviewing the fees paid for services rendered to their policyholders. *McGill, supra,* 207 Mich App at 408.

A year after *McGill*, the Court of Appeals went even further in *LaMothe v Auto Club Ins Ass'n*, *supra*, 214 Mich App at 582, holding that an insurer's **failure** to perform such evaluations would be a breach of the insurance policy and the Act, and that scrutiny of medical charges was "compelled" by the no-fault statute. The Court stated:

> The mere fact that those amounts [paid by ACIA] are not the same as the amounts charged by the health care provider does not, as plaintiff would have it, constitute a breach of the contract. Indeed, contrary to plaintiff's contention, if the insurance company paid the bills regardless of their reasonability, that action would, in fact, be in violation of the insurance contract.(fn3)
>
> (Fn3): Further, this scrutiny by the insurance company would be compelled even if the contract itself did not provide for it because the statute controlling these contracts for automobile insurance requires it. Under the Michigan automobile no-fault insurance act, MCL 500.3101 *et seq*; MSA 24.13101 *et seq*., insurers are responsible for 'all reasonable charges incurred for reasonably necessary products, services and accommodations for an insured person's care, recovery or rehabilitation.' MCL 500.3107(1)(a); MSA 24.13107(1)(a). Furthermore, in the same statute, the Legislature has decreed that a health care provider cannot lawfully charge more than a reasonable amount for those products, services, and accommodations. MCL 500.3157; MSA 24.13157. Thus, not only should an insurer audit and challenge the reasonableness of bills submitted by health care providers, but the providers should expect no less.

LaMothe, 214 Mich at 581-582 (emphasis added). *See also*, *Spect*, *supra*.

Thus, the law and public policy of Michigan are that no-fault insurance carriers must review claims submitted to them and pay only reasonable rates for reasonably necessary services. As part of this obligation, when a provider demands payment from a no-fault patient, the insurer

is required to step in and address the payment demand under the terms of the statute and the insurance policy. *McGill*, 207 Mich App at 406-07; *LaMothe*, 214 Mich App 583-585 (holding that insurers cannot retract promise to defend no-fault insureds); see also OAG, 1995, No 6865, p. 7 (August 18, 1995)("the no-fault insurer not only may but, indeed, must defend the interests of its insured").

Consistent with this precedent, the Commissioner has instructed no-fault insurers to intervene when a provider seeks to collect from an insured so that the insured is not exposed to harassment, dunning, disparagement of credit, or a lawsuit. Interpretative Statement, Bulletin 92-03 at pp 1-2.[36] As noted by the Sixth Circuit, the existence of the Commissioner's Bulletin "would certainly have lulled even the most skittish - or cynical - of insurers into believing that the sending of letters that complied with the bulletin's requirements was not a malicious act." *AOPP*, 176 F3d 315, 328 (1999).

The tortious interference claims here are similar to those presented in *Michigan Podiatric Medical Assoc, supra*, 175 Mich App 723. There, certain health care providers attempted to assert tortious interference claims against an alternative health care maintenance organization, which was alleged to have interfered with plaintiffs' abilities to provide health care to Chrysler Corporation employees. The Court of Appeals affirmed summary disposition of the tortious interference claim after determining that there was no constitutional violation:

> We agree with the trial court that plaintiffs' complaint is legally insufficient to sustain a claim for tortious interference with a business relationship. The only conduct denominated as illegal in plaintiffs' complaint is contained in the allegations pertaining to statutory violations and actions taken pursuant to unconstitutional delegation of legislative authority. Our prior conclusion that these

[36] While the Commissioner's Interpretative Statement does not have the full force and effect of law, a reviewing court generally gives deference to administrative agency interpretations. *McGill*, 207 Mich App at 407, n1.

> claims of "illegal" activity are not sustainable compels a conclusion that plaintiffs will be unable to establish either that defendant's conduct was wrongful per se or undertaken illegally and without justification.

175 Mich App 736-37 (emphasis added). The same result is appropriate here.[37]

B. The Tortious Interference Claims Fail Because Defendants Have Legitimate Business Reasons To Review The Medical Fees Charged By Providers And To Communicate With Patients And Providers.

"Where defendant's actions were motivated by legitimate business reasons, its actions would not constitute improper motive or interference." *BPS Clinical Labs v Blue Cross & Blue Shield of Michigan (On Remand)*, 217 Mich App 687; 552 NW2d 919 (1996), *lv den*, 456 Mich 881 (1997), *cert den*, 522 US 1153 (1998) (affirming grant of summary disposition of tortious interference claims based on health care insurer's preferred provider program). As a result, the Court affirmed the dismissal of the claims for tortious interference with contract and with business expectancies. *Id.* Nothing in the Complaint suggests that Defendants are not motivated by their perceived statutory and contractual obligations to their insureds in engaging in the conduct challenged as constituting interference. Since the Defendants plainly have a legitimate business interest in communicating with their insureds concerning balance billing (and have been instructed by their regulator to do so), dismissal of the tortious interference claims was proper.[38]

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[37] Plaintiffs argue that the trial court "overlooked" allegedly misleading or false statements made by certain insurers. (Plaintiffs' Brief, pp. 41-42.) Even if the statements of the law made in the letters were not true, that does not make them "fraudulent." Moreover, the Sixth Circuit rejected plaintiffs' characterization of the letters as fraudulent. *AOPP*, 176 F3d at 323-324. Plaintiffs did not appeal the lower court's dismissal of their fraud claim, thereby waiving this issue on appeal. *See*, *Wallad v Access BIDCO, Inc*, 236 Mich App 303, 309; 600 NW2d 664 (1999) (court will not consider issue not raised in the statement of questions involved); *Phinney v Perlmutter*, 222 Mich App 513, 564; 564 NW2d 532 (1997) (same). Of equal significance is the Sixth Circuit's observation that the letters sent by the plaintiff providers were just as "threatening" as those sent by the insurers. *AOPP*, 176 F3d at 326, n7.

[38] Plaintiffs rely heavily on *Dolenga v Aetna Cas & Surety Co*, 185 Mich App 620; 463 NW2d 179 (1990), a case not applicable here. In *Dolenga*, the issue was whether a workers' compensation insurer had the right to instruct a claimant that he was not allowed to treat with a provider of his choice. The court concluded that there were disputed issues of fact as to whether

C. Plaintiffs Cannot Establish A Breach Of Their Contractual Relationship With Patients, As Plaintiffs Are Precluded From Charging In Excess Of A Reasonable Fee By The No-Fault Act.

Dismissal was also appropriate because in order to sustain such a claim for tortious interference with a contract, "a plaintiff must establish a breach of contract [or business expectancy] caused by the defendant," *Dzierwa v Michigan Oil Co*, 152 Mich App 281, 287; 393 NW2d 610 (1986). Here, the Complaint fails to adequately plead such a breach, because the contracts and business expectancies alleged are proscribed by the No-Fault Act and therefore would violate public policy. As stated in *LaMothe*, health care providers should expect that their medical invoices will be reviewed, and thus can have no valid expectancy that whatever they want to charge will be paid. *LaMothe*, 214 Mich App at 582, n 3.

Furthermore, the "contract" which plaintiffs seek to protect is a "contract" which would permit providers to charge no-fault patients at any rate of compensation the providers select. (Complaint, p. 59, ¶ 124(4)).[39] This request flies in the face of Michigan law, as set forth by this Court in *Nasser v Auto Club Ins Ass'n*, 435 Mich 33; 457 NW2d 637 (1990):

> We question, in any event, the Court of Appeals apparent conclusion that if the insurer is not made liable for even unreasonable and unnecessary expenses it will inevitably fall to plaintiff to pay those expenses. To the extent that plaintiff has any

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the providers acted with an improper motive. Here, plaintiffs "pled no facts sufficient to raise an inference that the Defendants acted with a malicious intent when they sent the letters at issue." *AOPP*, 176 F3d at 327. Indeed, there can be no dispute that the insurers were following the instructions of their primary regulator, the Insurance Commissioner, a fact noted by the Sixth Circuit in rejecting plaintiffs' fraud claims. *AOPP*, 176 F3d at 327-328. Moreover, as the Court of Appeals noted, there is no evidence that Defendants required insureds to switch providers. 257 Mich App at 384.

[39] Plaintiffs' Brief states that "there is no dispute that contracts existed" between the providers and their patients. (Plaintiffs' Brief, p. 39.) Notably, there is no record citation for this assertion, and defendants do not agree with it. Plaintiffs conceded at the beginning of this litigation that there were no written contracts between patients and providers, and they are relying on a "constructive" contract allegedly resulting from rendering services to patients. (Complaint, ¶59.)

> liability for these expenses in the event his insurance does not pay, it is presumably contractual. It seems unlikely that plaintiff would have an express agreement with [the doctor] or the hospital to pay unreasonable and unnecessary medical expenses, and equally as unlikely that he would have an implied contractual duty to do so. See 61 Am Jur 2d, Physicians, Surgeons, and Other Healers, § 158, pp. 290-291. And, while we need not resolve the issue in this case, it seems unlikely that medical expenses found to be unreasonable or unnecessary in a no-fault action would be found recoverable in a contract action against plaintiff.

Id., 435 Mich at 55-56, n.10 (emphasis added); *see also*, *McGill*, 207 Mich App at 406; *Mercy Mt Clemens Corp, supra*, 219 Mich App at 51 ("Section 3157 of the act prohibits medical providers from charging more than a reasonable fee."); *LaMothe*, 214 Mich App at 582, n.3 ("The Legislature has decreed that a health care provider cannot lawfully charge more than a reasonable amount for ... products, services, and accommodations."); *Munson Medical Center v Auto Club Ins Ass'n, supra* (hospital is to be reimbursed by the insurer pursuant to the provisions of the Act). This is consistent with Michigan law generally, which will not enforce a contract that violates a statute or which is otherwise illegal. *See, e.g.*, *Turner v Schmidt Brewing Co*, 278 Mich 464; 270 NW 750 (1936); *Cook v Wolverine Stockyards Co*, 344 Mich 207, 209-10; 73 NW2d 902 (1955).

Plaintiffs also argue that the defendants' actions are "unlawful" if the actions are designed to bring about a breach of contract, citing *Bahr v Miller Bros Creamery*, 365 Mich 415; 112 NW2d 463 (1961) and *Woody v Tamer*, 158 Mich App 764; 405 NW2d 213 (1987). This argument fails because it is missing the fundamental point – "improper interference" requires both the absence of justification and the purpose of interfering with plaintiffs' contract rights or business expectancy. *Winiemko v Valenti*, 203 Mich App 411, 418, n 3; 513 NW2d 181 (1994, *lv den*, 448 Mich 854 (1995), and *Bahr*, 365 Mich at 422 (actionable "unless reasonable

justification or excuse can be shown.") Here there was a justification for defendants' actions – the words of the No-Fault Act and Michigan case law.

Because the No-Fault Act permits health care providers to charge only reasonable rates for reasonably necessary procedures, Plaintiffs cannot establish as a matter of law that Defendants caused any breach of any contract to charge more than that, and the lower court properly dismissed the tortious interference claims as a matter of law.

RELIEF REQUESTED

The decision of the Court of Appeals should be affirmed.

(These signature pages have been executed by Lori McAllister on behalf of the designated counsel with consent of the party indicated.)

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